Appendix G: Provider Forms

These are sample forms only; to reproduce a form, please download it from DMA's Web site (http://www.ncdhhs.gov/dma/forms.html).

SAMPLE OF FEE SCHEDULE REQUEST FORM

Fee Schedule Request Form

There is no charge for fee schedules requested from the Division of Medical Assistance (DMA). . **Providers are expected to bill their usual and customary rate.** Please note that fee schedules change regularly and you will be provided the most current version upon the receipt of your request.

All requests for fee schedules **must be made** on the Fee Schedule Request form and mailed to:

Division of Medical Assistance
Finance Management/Rate Setting - Fee Schedules
2501 Mail Service Center
Raleigh, N. C. 27699-2501

Or **fax** your request to DMA's Finance Management/Rate Setting section at **919-715-2209**.
Please note that many fee schedules can be directly accessed and obtained at our website www.dhhs.state.nc/dma. If you can not get your schedule then submit this form.

NOTE: PHONE REQUESTS ARE NOT ACCEPTED

- ☐ Adult Care Homes Personal Care Services (ACH-PCS)
- ☐ Ambulance
- ☐ Community Alternatives Program (CAP-MR/DD, CAP-AIDS, CAP-DA, CAP-C)
- ☐ Dental
- ☐ Durable Medical Equipment
- ☐ Health Department
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Psychologist
- ☐ Nurse Midwife
- ☐ Occupational Therapist
- ☐ Orthotics and Prosthetics
- ☐ Physical Therapist
- ☐ Physician Fees (includes x-ray and laboratory, nurse midwife, optical)
- ☐ Respiratory Therapy
- ☐ Speech Therapy

Name(Provider/Facility): _____ Provider Type: _____

Address: _____Provider #: _____

_____

_____

E-Mail Address_____

Contact Person: _____ Phone: _____

Date of Request: _____

Format of fee schedule requested (circle one of each) **Emailed** or **Disk copy** / **Excel** or **Adobe version**

1 **2/21/06**

SAMPLE MEDICAID PROVIDER CHANGE FORM

North Carolina Division of Medical Assistance
MEDICAID PROVIDER CHANGE FORM

FOR DMA USE ONLY
Date keyed: _____
Initials: _____

Items 1 and 4 are required. (Please print) Complete other information only if there is a change.

1.

❑ Terminate your participation. Reason:	
Medicaid Provider Number (*one provider number per form*):	NPI# or Change NPI#: (please attach copy of NPPES)
Provider Name:	
Type of Provider: ❑ Individual ❑ Group ❑ Carolina ACCESS (skip to #3)	
Effective Date of Change:	

2. Type of Change: If you are an Endorsed or DFS licensed provider, please include a copy of your updated Endorsement and/or license.

❑ Physical		□ Mailing/Payment Address	
Physical Address:		Mailing/Payment Address:	
City:		City:	
State:	Zip Code + Plus 4 (Required):	State:	Zip Code + Plus 4 (Required):
Change County to:		Administrative/Accounting Phone:	
Office/Site Phone:		Fax#:	Email:

❑ Add or ❑ Delete Individual to/from a Group *(The group's name and provider number must be entered in Item 1.)*

First, Last Name / Specialty (Required)	License No. / State (Required)	Social Security Number (Required)	Individual N.C. Medicaid Provider Number (Required)

❑ Specialty change to *(attach copy of new certification)*:

❑ Change in bed capacity from beds to beds *(Attach state license reflecting bed capacity change)*

❑ Provider Name Change: *(Attach State license reflecting new name and a completed IRS Form W-9)*

Previous Name: New Name:

Reason:

❑ CLIA Certification Renewal *(attach a copy of your renewed CLIA certificate)*

❑ Change of Ownership (CHOW), Change of Federal Tax Identification Number or Tax Name
(Attach a completed IRS Form W-9. Attach a copy of your IRS Tax ID letter if you are a Sole Proprietor.) Effective Date:

3. Changes for Carolina Access Providers only:

❑ Change CA practice provider number to: _____
Reason:

❑ Change in contact person's name:

❑ After-Hours Phone

❑ Change enrollment restriction information (i.e. ages 15 and up only):

❑ Change enrollment limit from: to:

❑ Add counties served:

❑ Delete counties served:

❑ Other:

4. _____
Form Completed By: **Title** **Phone Number**

Signature: _____ **Date:** _____

To reach The Division of Medical Assistance Provider Services Section call (919) 855-4050
Mail this form to: DMA Provider Services, 2501 Mail Service Center Raleigh, N.C. 27699-2501. 7/2007

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SAMPLE OF ADVANCE DIRECTIVES BROCHURE

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?
You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?
Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?
An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?
Your health care provider can tell you how to get more information about advance directives by contacting:

This document was developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.

Medical Care Decisions and Advance Directives
What You Should Know

What are My Rights?

Who decides about my medical care or treatment?
If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?
An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?
Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

1

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your

Sample of Health Check Agreement Between Primary Care Provider (PCP) and the Local Health Department

HEALTH CHECK AGREEMENT BETWEEN PRIMARY CARE PROVIDER (PCP) AND THE LOCAL HEALTH DEPARTMENT

For recipients of Medicaid, birth to age 21, the Health Check Medical Screening Exam is required as a comprehensive preventive service at age appropriate intervals. There are numerous components of the health check exam, all of which are required in the Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in the attached document "Health Check Screening Components."

WHAT IS AN AGREEMENT FOR HEALTH CHECK?

If a Carolina ACCESS PCP cannot or chooses not to perform the comprehensive health check screenings, this agreement allows the PCP to contract with the Health Department serving the PCP's county to perform the screenings for enollees in the birth to 21 year age group.

The agreement requires the following:

- The Health Department must provide the results of the exam to the PCP within 30 days unless follow-up is necessary, in which case, the Health Department must communicate the results of the screening within 24 hours.
- The PCP is required to coordinate any necessary treatment or follow-up care as determined by the screening.
- Under this agreement, the health department must perform all health check components at the time of the appointment unless circumstances require an appointment be rescheduled.

If the PCP chooses to utilize this agreement in order to meet this Carolina ACCESS requirement for participation, the agreement containing the original signatures of the PCP or the authorized representative and the Director of the Health Department or an authorized representative must be submitted to the Division of Medical Assistance (DMA). The PCP must keep a copy of this agreement on file.

This agreement can be entered into or terminated at any time by the PCP or the Health Department. DMA must be notified immediately of any change in the status of the agreement.

Questions regarding this agreement or health check requirements can be made to DMA CA-CCNC at 919-647-8170 or by contacting the regional Managed Care Consultant.

CA 11/06

AGREEMENT BETWEEN PRIMARY CARE PROVIDER AND HEALTH DEPARTMENT TO PROVIDE HEALTH CHECK SERVICES TO CAROLINA ACCESS PATIENTS

In order to provide coordinated care to those children who are enrolled in Carolina ACCESS and obtain primary care services from _____ and Health Check services and immunizations from _____ County Health Department (CHD), the undersigned agree to the following provisions.

Primary Care Provider agrees to:

1. Refer Carolina ACCESS patients to the CHD for Health Check appointments. If the patient is in the office, the physician/office staff will assist the patient in making a Health Check appointment with the CHD.
2. Maintain, in the office, a copy of the physical examination and immunization records as a part of the patient's permanent record.
3. Monitor the information provided by the CHD to assure that children in the Carolina ACCESS program are receiving immunizations as scheduled and counsel patients appropriately if they are noncompliant with well child visits or immunizations.
4. Review information provided by the CHD and follow up with patients when additional services are needed.
5. Provide the Division of Medical Assistance Managed Care Section at least thirty (30) days advance notice if the Primary Care Provider (PCP) and/or the CHD wishes to discontinue this Agreement.

The Health Department agrees to:

1. Provide age appropriate Health Check examinations and immunizations within ninety (90) days of the request for patients who are referred by the PCP or are self-referred.
2. Send Health Check physical examination and immunization records monthly to the Primary Care Provider.
3. Notify the Primary Care Provider of significant findings on the Health Check examination within twenty-four (24) hours. Allow the Primary Care Provider to direct further referrals for specialized testing or treatment.
4. Provide the Division of Medical Assistance Managed Care Section thirty (30) days advance notice if the Primary Care Provider and/or the CHD wishes to discontinue this Agreement.

_____ _____ _____
Signature of Primary Care Provider or Authorized Official Date PCP Medicaid Provider #

_____ _____
Printed Name of Provider or Authorized Official Provider Group Name (if applicable)

_____ _____
Signature of Health Department Director/Designee Date

_____ _____
Printed Name of Health Department Director/Designee Health Dept. Provider Number

cc: DMA CCNC, Assistant Director

.

CA 11/06

Sample of Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement

CAROLINA ACCESS HOSPITAL ADMITTING REQUIREMENT

The establishment of a continuous and comprehensive patient/provider relationship is an essential component of Carolina ACCESS. Therefore, Carolina ACCESS (CA) primary care providers (PCPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addresses the needs all enrollees or potential enrollees. If the CA practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the North Carolina Medicaid program, then the *Carolina ACCESS Hospital Admitting Agreement* form must be submitted to DMA Provider Services to address this requirement for participation. To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the *Carolina ACCESS Hospital Admitting Agreement* form, which serves as the written agreement between the two parties. **IF the Carolina ACCESS provider has entered into a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the application for participation or when a change occurs regarding the provider's management of inpatient hospital admissions.**

> **Note:** A *formal arrangement* is defined as a voluntary agreement between the Carolina ACCESS primary care provider and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Carolina ACCESS enrollee throughout the inpatient stay.

The following Carolina ACCESS requirements regarding inpatient hospital care must be met:

1. Under the conditions stated above, the CA PCP must provide inpatient hospital care, or have a signed *Carolina ACCESS Hospital Admitting Agreement* form on file at DMA.
2. All ages of the provider's CA enrollees or potential enrollees must be covered by the inpatient hospital care or formal arrangement for inpatient hospital care or a combination of the two.
3. If the *Carolina ACCESS Hospital Admitting Agreement* form is utilized, the Agreement(s) must be between the CA PCP and one or more of the following:
   - a physician
   - a group practice
   - a hospitalist group
   - a physician call group

   Note: The above providers must be enrolled as NC Medicaid providers, but it is not necessary that they be enrolled as Carolina ACCESS providers. Admissions through unassigned hospital-based call groups do <u>not</u> meet this requirement.
4. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five (45) minutes drive time from the CA PCP's practice.
   Note: If there is no hospital that meets the above geographical criteria, *the hospital geographically closest to the CA PCP's (Contractor's) practice will be accepted.*
5. Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.
   Note: For more information refer to the *Agreement for Participation as a Primary Care Provider in North Carolina's Patient Access and Coordinated Care Program*, Section IV, 6.4.

Questions regarding hospital admitting privileges may be directed to DMA Managed Care by calling 919-647-8170.

09/2006

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
Provider Services
2501 Mail Service Center Raleigh, NC 27699-2501 (919) 855-4050
http://www.dhhs.state.nc.us/dma

Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement

This form is to be completed only if the Carolina ACCESS (CA) Primary Care Provider (PCP) does not provide inpatient hospital care that addresses the needs of the CA enrollees or potential enrollees.

Carolina ACCESS Primary Care Provider or Applicant:
(First Party Section)

CA PCP Applicant Name:_____ CA Provider Number: _____
Mailing Address: _____
_____
Contact Person: _____ Telephone Number: _____

To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement form. This form serves as a formal written agreement established between the two parties as follows:

- The Carolina ACCESS Primary Care Provider is privileged to refer Carolina ACCESS patients to the second party for hospital admission. The second party is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
- The second party will arrange coverage for Carolina ACCESS enrollee admissions during their vacations.
- Either party may terminate this agreement at any time by giving written 30 days advance notice to the other party or by mutual agreement.
- The Carolina ACCESS Primary Care Provider will notify Carolina ACCESS in writing of any changes to or terminations of this agreement.
- The Carolina ACCESS Primary Care Provider will provide the second party with the appropriate payment authorization number.

Physician and/or Group Agreeing to Cover Hospital Admissions For Above Carolina ACCESS Primary Care Provider Applicant:
(Second Party Section)

Physician/Group Name: _____
Medicaid Provider Number: _____
Mailing Address: _____
_____
Specialty: _____ Ages Admitted: _____
Hospital Affiliation(s) and Location(s): _____
_____
Contact Person: _____ Telephone Number: _____
Authorized Signature: _____ Date: _____

09/2006

SAMPLE OF WIC EXCHANGE FOR INFORMATION FOR WOMEN

1. Last Name First Name MI

2. Patient Number — H

3. Date of Birth Month Day Year

4. Race ☐ 1. White ☐ 2. Black ☐ 3. Am. Ind. ☐ 4. Other Ethnicity: Hispanic Origin? ☐ 1. Yes ☐ 2. No

5. Sex ☐ 1. Male ☐ 2. Female

6. County of Residence

I authorize the exchange of the information below between the WIC Program and my Health Care Provider.

Client's Signature: _____

Date: _____

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Nutrition Services Branch • WIC Program

WIC PROGRAM EXCHANGE OF INFORMATION – WOMEN –

WIC is an Equal Opportunity Program.

RETURN COMPLETED FORM TO:

Local WIC Agency / Address / Phone

↓ ***Information Below To Be Completed By The Health Care Provider*** ↓

1. Actual or Expected Date of Delivery: _____

2. Enter date & results of most recent measurements:
   Date _____ Weight_____
   Date _____ Height_____
   Date _____ Hemoglobin _____ OR Hematocrit _____

3. Significant Obstetric History:

4. Findings / Diagnosis / Recommendations:

5. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❑ Yes ❑ No

Completed by:_____**Date:**_____**Phone:**_____
Signature/Title

SUMMARY OF NUTRITION SERVICES ***(to be completed by the WIC Program Staff)***

Date:_____ Signature/Title:_____Phone No.:_____

DHHS 3492 (Revised 3/00)
DPH/WCHS/Nutrition Services Branch/WIC Program (Review 3/03)

WIC Program Exchange of Information
(DHHS 3492)

PURPOSE: To facilitate transmittal of information necessary for WIC certification between a health care provider and the local WIC Program.

GENERAL INSTRUCTIONS: The appropriate side of the form (infants/children or women) should be initiated by the local WIC Program with the following information completed.

WIC Agency/Address/Phone: of local WIC Program where person receives program services.

Patient name/DOB: of person being referred.

Client's Signature/Date: authorizing the exchange of information.

The health care provider should complete the relevant medical information, sign and date the form, and return it to the Local WIC Program.

If requested, the local WIC Program should provide a summary of nutrition services to the referring individual.

DISTRIBUTION: Maintain a copy of the WIC Program Exchange of Information form in the Health Record. Send a copy to the referring health care provider if requested.

DISPOSITION: This form may be destroyed in accordance with the Patient Clinical Records Standard of the *Records Disposition Schedule* published by the Division of Archives and History.

REORDER INFORMATION: Additional copies of this form may be ordered on the Nutrition Services Branch Requisition Form, DHHS 2507, from:

Nutrition Services Branch
1914 Mail Services Section
Raleigh, NC 27699-1914

SAMPLE OF WIC EXCHANGE FOR INFORMATION FOR INFANTS AND CHILDREN (WITH INSTRUCTIONS)

1. Last Name First Name MI

2. Patient Number ____ — H

3. Date of Birth Month Day Year

4. Race ☐ 1. White ☐ 2. Black ☐ 3. Am. Ind. ☐ 4. Other Ethnicity: Hispanic Origin? ☐ 1. Yes ☐ 2. No

5. Sex ☐ 1. Male ☐ 2. Female

6. County of Residence

I authorize the exchange of the information below between the WIC Program and my Health Care Provider.

Client's Signature: _____

Date: _____

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Nutrition Services Branch • WIC Program

WIC PROGRAM EXCHANGE OF INFORMATION – INFANTS & CHILDREN –

WIC is an Equal Opportunity Program.

RETURN COMPLETED FORM TO:

Local WIC Agency / Address / Phone

↓ ***Information Below To Be Completed By The Health Care Provider*** ↓

1 Infant / Child is insured through (✓ one): ❑ Health Choice ❑ Medicaid ❑ Other ❑ No Insurance

2. If child is ≤24 months of age: Birthweight:_____ Birth Length: _____ Weeks Gestation: _____

3. Enter date & results of ***most recent*** measurements / tests:

Date _____ Weight _____

Date _____ Recumbent Length: _____ or Standing Height: _____

Date _____ Hemoglobin: _____ or Hematocrit: _____

Date _____ Blood Lead: _____ or ❑ Results not yet available

4. Immunization Status (✓ one): ❑ Up-to-Date ❑ Not Up-to-Date

5. **Complete only if infant** is 12 months or younger **and** drinking a formula other than Enfamil w/iron, Lactofree, or ProSobee.

a. Name of Prescribed Formula: _____

b. Reason infant **cannot** consume Enfamil w/ Iron, Lactofree, or ProSobee:

❑ Formula Intolerance → ❑ chronic diarrhea ❑ persistent dermatological condition
❑ persistent vomiting ❑ persistent respiratory condition

❑ Medical Diagnosis / Condition (specify): _____

c. Duration of prescribed formula use (✓ one): ❑ 1 month ❑ 2 months ❑ 3 months ❑ Other _____

d. At the end of the prescribed duration (✓ one):

❑ I must reassess the infant before there are any formula changes.

❑ WIC Staff may rechallenge the infant with → ❑ Enfamil w/ Iron ❑ Lactofree ❑ ProSobee

e. Special Instructions for Formula (i.e., dilution) / Findings / Other Recommendations:

6. **Complete only if child** is older than 12 months of age **and** drinking any formula.

a. Name of Prescribed Formula: _____

b. Medical Diagnosis / Condition (specify): _____

c. Duration of prescribed formula use (✓ one): ❑ 6 months ❑ Other *(specify)* _____

d. Special Instructions for Formula (i.e., dilution) / Findings / Other Recommendations:

7. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❑ Yes ❑ No

Completed by:_____ **Date:**_____ **Phone:** _____
Signature/Title

DHHS 3492 (Revised 3/00)
DPH/WCHS/Nutrition Services Branch/WIC Program (Review 3/03)

WIC Program Exchange of Information
(DHHS 3492)

PURPOSE: To facilitate transmittal of information necessary for WIC certification between a health care provider and the local WIC Program.

GENERAL INSTRUCTIONS: The appropriate side of the form (infants/children or women) should be initiated by the local WIC Program with the following information completed.

WIC Agency/Address/Phone: of local WIC Program where person receives program services.

Patient name/DOB: of person being referred.

Client's Signature/Date: authorizing the exchange of information.

The health care provider should complete the relevant medical information, sign and date the form, and return it to the Local WIC Program.

If requested, the local WIC Program should provide a summary of nutrition services to the referring individual.

DISTRIBUTION: Maintain a copy of the WIC Program Exchange of Information form in the Health Record. Send a copy to the referring health care provider if requested.

DISPOSITION: This form may be destroyed in accordance with the Patient Clinical Records Standard of the *Records Disposition Schedule* published by the Division of Archives and History.

REORDER INFORMATION: Additional copies of this form may be ordered on the Nutrition Services Branch Requisition Form, DHHS 2507, from:

Nutrition Services Branch
1914 Mail Services Section
Raleigh, NC 27699-1914

SAMPLE OF MEDICAL RECORD RELEASE FOR WIC REFERRAL

MEDICAL RECORD RELEASE

I, the undersigned, give permission for my provider, acting on my behalf, to refer my name for WIC services and to release necessary medical record information to the WIC agency.

Signature _____

(signature of patient being referred or, in case of children and infants, the signature and printed name of the parent/guardian)

Date _____

SAMPLE OF CAROLINA ACCESS OVERRIDE REQUEST

Carolina ACCESS Override Request Form

Complete this form to request a Carolina ACCESS override when you have received a denial for EOB 270 or 286 **or** the Primary Care Provider (PCP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted within six months of the date of service. Overrides will not be considered unless the PCP has been **contacted and refused** to authorized treatment. Attach any supporting documentation. Mail or fax completed form to EDS. EDS will telephone or fax your office **within 30 days** with a denial or, if approved, the override number to use for filing the claim. This form is also available in the Carolina ACCESS Primary Care Provider Manual and on DMA's website at http://www.dhhs.state.nc.us/dma.

Mail to: CA Override
EDS Provider Services
PO Box 300009
Raleigh, NC 27622

Fax: CA Override
919-816-4420

Recipient MID No. _____ Recipient Name _____

Date of Birth _____ Date(s) of Service _____

Is this claim due to?

- o An Inpatient admission
- o An Inpatient admission via the ER
- o Current condition _____

PCP on recipient's Medicaid card _____

Name of person contacted at PCP's office _____ Date contacted _____
Reason PCP stated he/she would not authorize treatment _____
_____

Reason recipient did not go to the PCP listed on his/her Medicaid card _____
_____

I am requesting an override due to:

- o Enrollee linked incorrectly to PCP. Please explain: _____
  _____
  Who is the correct PCP? _____
- o This child has been placed in foster care in another area : _____
- o This enrollee has moved to another county: _____
- o The provider listed on the enrollee's Medicaid card is different from PCP indicated by the AVR system (attach a copy of the Medicaid card with this form).
- o Unable to contact PCP. Please Explain: _____
- o Other. Please explain: _____

Provider Name _____ Provider Number _____

Provider Contact _____ Telephone No. _____ Fax No. _____

Revised 5/1/2006

Sample of Carolina Access Medical Exemption Request (DMA-9002)

Carolina ACCESS Medical Exemption Request

Carolina ACCESS PCCM model was established in 1991based on the premise that patient care is best served by a medical home where a Primary Care Provider (PCP) may coordinate care. The purpose of this form is for the provider to list the reasons why a recipient would not benefit from this system of care.

Attention Recipient: Please fill out this section of the form consisting of recipient's name, MID#, DOB and county of residence

_____	_____	_____	_____
(Recipient Name)	(MID#)	(DOB)	(County of Residence)

Attention Physician: The following section is to be completed only by a physician providing direct medical care to the recipient. Please check all blocks that apply regarding the recipient's medical condition and mail to the address below. All incomplete forms will be returned to the physician.

☐ **Terminal illness** (the recipient has a six (6) month or less life expectancy and/or is currently a hospice patient.)

☐ **Major Organ Transplant:** Specify organ_____

☐ Currently undergoing **Chemotherapy** or **Radiation treatments.** (**Note**: Exemptions for this purpose are temporary until the completion of the therapy. If the therapy will last longer than 6 months, exemption must be requested after the 6 month time period during reapplication for Medicaid coverage.)

☐ **Diagnosis/Other information:** Specify reasons why this recipient would not benefit from having a medical home with a local PCP who would coordinate their care. **Supporting medical record documentation must be submitted with this request.**

_____
_____
_____
_____
_____
_____
_____

Pursuant to federal regulations regarding utilization of Medicaid services, the Division of Medical Assistance is authorized by Section 1902 (a) (27) of the Social Security Act and Federal Regulation 42 CFR 431.107 to access information from the recipient's medical records for the purposes directly related to the administration of the Medicaid Program. Therefore, no special recipient permission is necessary for the release of medical records. In addition, when applying for Medicaid benefits, each recipient signs a release, which authorizes access to his/her Medicaid records by the appropriate authorities.

_____	_____	_____
(Physician Signature)	**(Medicaid Provider No.)**	**(Date)**

_____	_____	_____
(Print Physician Name)	**(Telephone Number)**	**(Fax Number)**

Sign and mail completed forms to: DMA/ Managed Care
2501 Mail Service Center
Raleigh, NC 27699-2501

*If you have any questions or would like to apply to become a Carolina ACCESS provider, please contact DMA/Managed Care at (919) 647-8170.

DMA-9002 (1/05)
Carolina ACCESS

SAMPLE OF CERTIFICATION OF SIGNATURE ON FILE

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION

FOR

SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

Group or attending provider number to which this certification applies:_____

(Leave blank if submitting with new enrollment packet. A provider number will be assigned once enrollment is complete. This certification is only applicable to the provider number listed above. When the attending number is required on a claim form, each attending provider is required to fill out a separate certification in addition to the group certification.)

_____

Provider Name (must exactly match name on application)

_____

Signature of Provider Listed Above or Authorized Agent Date
(Authorized Agent only applicable for group provider numbers)

Mail completed form to:
(Must be original, faxes not accepted)

DMA-Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

SAMPLE OF MEDICARE CROSSOVER REFERENCE REQUEST

Medicare Crossover Reference Request

Provider Name: _____

Contact Person (required): _____ Telephone (required): _____

Select the appropriate *Medicare Carrier/Intermediary/DMERC* from the following listing, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers. **If this section is not completed, the form will not be processed.** These are the only carriers for which EDS can currently cross-reference provider numbers.

Medicare Part A Intermediaries

- ☐ Riverbend GBA Medicare Part A (Tennessee) http://www.riverbendgba.com
- ☐ Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina) http://www.palmettogba.com
- ☐ Trailblazer Medicare Part A (Colorado, New Mexico and Texas) http://www.the-medicare.com
- ☐ United Government Services Medicare Part A (Wisconsin) http://www.ugsmedicare.com
- ☐ Palmetto Medicare Part A (South Carolina) http://www.palmettogba.com*
- ☐ AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky) http://www.adminastar.com*
- ☐ Carefirst of Maryland Medicare Part A (Maryland) http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm*
- ☐ Veritus Medicare Part A (Pennsylvania) http://www.veritusmedicare.com*
- ☐ First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida) http://www.floridamedicare.com *

Medicare Part B Carrier

- ☐ CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho) http://www.cignamedicare.com
- ☐ AdminaStar Medicare Part B (Indiana and Kentucky) http://www.adminastar.com*
- ☐ Palmetto Medicare Part B (South Carolina) http://www.palmettogba.com*

Medicare Regional DMERC

- ☐ Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands); http://www.palmettogba.com

*Trading Partners currently in testing phase.

Action to be taken:

☐ ***Addition*** *- This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

☐ ***Change*** *- This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

Mail completed form to:
P.O. Box 300009
Raleigh, NC 27622
FAX: 1-919-851-4014
1-800-688-6696

PVS002 Revised 07/04

SAMPLE OF HEALTH INSURANCE INFORMATION REFERRAL (DMA-2057)

Division of Medical Assistance
Health Insurance Information Referral Form

Recipient Name: _____

Recipient ID No: _____ Date of Birth: _____

Health Ins. Co. Name (1) _____ Policy/Cert No._____

(2) _____ Policy/Cert No._____

Reason For Referral

1._____ Recipient never covered by or added to above policy(s) (**EOB attached**)

2._____ Recipient's insurance coverage terminated (**EOB attached**)

3. _____ New policy not indicated on Medicaid ID card (**EOB or copy of insurance card attached**) Indicate type coverage:

(Do not include Medicare)

_____ Major Medical	_____ Hosp/Surgical	_____ Basic Hospital
_____ Dental	_____ Cancer	_____ Accident
_____ Indemnity	_____ Nursing Home	

Attach original claim, a copy of the EOB **or** a copy of the insurance card and submit to: DMA - TPR, 2508 Mail Service Center, Raleigh, North Carolina 27699-2508. The Third Party Recovery (TPR) Section will update the system and forward claims to EDS within 10 working days after receipt.

Provider Name:_____ Provider Number: _____

Submitted By:_____ Date Submitted: _____

Telephone Number: _____

DMA 2057
Revised January 2003

SAMPLE OF THIRD PARTY RECOVERY (TPR) ACCIDENT INFORMATION REPORT (DMA-2041)

THIRD PARTY RECOVERY
INSURANCE INFORMATION
CHECK ONE to select action.

☐ **TA**-Add policy (Must include at least one individual.), add individual to a policy, update policy, delete policy.

☐ **TU**-Update individual coverage.

WKR	CTY	DIST	DELETE POLICY
			☐
POLICY NUMBER	INS COMP CD	INS TYPE CD	

POLICY HOLDERS NAME	GRP POLICY	GROUP POLICY NAME

GROUP ADDRESS		CITY	STATE	ZIP

INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N

For filing purposes:

CASEHEAD NAME	EIS CASE ID	CO CASE	WORKER	DISTRICT

DMA-2041 (04/03)

SAMPLE OF HEALTH INSURANCE PREMIUM PAYMENT (HIPP) APPLICATION (DMA-2069)

HEALTH INSURANCE PREMIUM PAYMENT (HIPP)
Application Form

Name of Applicant / Recipient	Medicaid I.D. Number
Applicant/Recipient Address	Social Security Number
City, State, Zip	Area Code/Phone Number
Name and Address of Insurance Carrier	Policyholder's Name
	Policy Number
	Policyholder's Social Security Number
	Premium Amount /Month

Source of Insurance (check one) ☐ Employee Group Plan ☐ Self Employed ☐ COBRA

How are premiums paid? (Check appropriate box)

1. ☐ Paid by insured to insurance carrier
2. ☐ Paid by insured to employer
3. ☐ Payroll deduction

Type of policy (Check appropriate box)

1. ☐ Single Coverage
2. ☐ Family Coverage

Name of Employer: _____

Address of Employer: _____

_____

Employer Telephone Number: _____

This person has been diagnosed as having _____ .

This person has been tested positive for (HIV). ☐ Yes ☐ No

If yes, please attach a copy of the most recent laboratory test.

This form must be accompanied by an itemization from the private insurance carrier for all claims submitted for the previous three months.

Submit completed form to:

HIPP Coordinator
Third Party Recovery Section
2508 Mail Service Center
Raleigh, NC 27699-2508
(919) 647-8100 or 1-800-662-7030

DMA-2069 (5/2007)

SAMPLE OF MEDICAID CREDIT BALANCE REPORT

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____

PROVIDER NUMBER: _____ TELEPHONE NUMBER: (_____) _____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR:_____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: **Third Party Recovery**
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 9/03

(See back of form for instructions)

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number. **DO NOT MIX**
- Circle the date of quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 - The month, day, and year of ending service (e.g., 12/10/03)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

SAMPLE MEDICAID ADJUSTMENT REQUEST

MEDICAID CLAIM ADJUSTMENT REQUEST

(This form is not to be used for claim inquiries or time limit overrides.)
PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:
EDS ADJUSTMENT UNIT
PO BOX _____(PAYER SPECIFIC)
RALEIGH, NC 27622

A CORRECTED CLAIM AND THE APPROPRIATE RA MUST BE ATTACHED

EDS USE ONLY

One Step: _____

Provider #:_____ Provider Name:_____

Recipient Name:_____ MID#:_____

SUBMIT A COPY OF THE RA WITH REQUEST Claim #:

Date Of Service: From:_____/_____/_____ To: _____/_____/_____ Billed Amount: $_____ Paid Amount: $_____ RA Date: _____/_____/_____

Please check (✓) reason for submitting the adjustment request:

☐ Over Payment ☐ Under Payment ☐ Full Recoupment ☐ Other

Please check (✓) changes or corrections to be made:

☐ Units ☐ Procedure/Diagnosis Code ☐ Billed Amount

☐ Dates of Service ☐ Patient Liability ☐ Further Medical Review

☐ Third Party Liability ☐ Medicare Adjustments (Attach all related Medicare Vouchers) ☐ Other

EDS USE ONLY **Do not write in this block**

Please Specify Reason for Adjustment Request:

Signature Of Sender: Date: / / Phone #: ( ) -

EDS INTERNAL USE ONLY

Clerk ID#:_____Sent to:_____ Date sent:_____/_____/_____

Reason for review:_____

Reviewed by:_____ Date reviewed:_____/_____/_____

Outcome of review:_____

Date received back in the Adjustment Department: _____/_____/_____

Revised 07/07/03

SAMPLE OF PHARMACY ADJUSTMENT REQUEST

PHARMACY ADJUSTMENT REQUEST

MAIL TO :
EDS CORPORATION
POST OFFICE BOX 300009
RALEIGH, NORTH CAROLINA 27622

ATTN: ADJUSTMENT UNIT

RECIPIENT MEDICAID NUMBER

PHARMACY NAME AND PROVIDER NUMBER

RECIPIENT NAME
LAST FIRST MIDDLE

PLEASE PRINT OR TYPE (BLACK OR DARK BLUE ONLY) **LIST INFORMATION AS GIVEN ON RA**

0 | Rx NUMBER | DRUGNAME-STRENGTH-DOSAGE-MFG | NDC | QUANTITY | BILLED AMOUNT
DATE FILLED MO DAY YR | CLAIM NUMBER | DENIAL EOB | INS PAID
ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) | PAID AMOUNT

1 | Rx NUMBER | DRUGNAME-STRENGTH-DOSAGE-MFG | NDC | QUANTITY | BILLED AMOUNT
DATE FILLED MO DAY YR | CLAIM NUMBER | DENIAL EOB | INS PAID
ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) | PAID AMOUNT

2 | Rx NUMBER | DRUGNAME-STRENGTH-DOSAGE-MFG | NDC | QUANTITY | BILLED AMOUNT
DATE FILLED MO DAY YR | CLAIM NUMBER | DENIAL EOB | INS PAID
ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) | PAID AMOUNT

3 | Rx NUMBER | DRUGNAME-STRENGTH-DOSAGE-MFG | NDC | QUANTITY | BILLED AMOUNT
DATE FILLED MO DAY YR | CLAIM NUMBER | DENIAL EOB | INS PAID
ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) | PAID AMOUNT

"This is to certify that the foregoing information is true, accurate, and complete. I understand that payment will be from Federal and State funds, and that any false claims, statements, or documents, or concealment, of a material fact, may be prosecuted under applicable Federal or State laws."

X_____
CLAIMANT SIGNATURE DATE

IMPORTANT: THIS FORM WILL BE RETURNED IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING IS NOT PRESENT.

FORM NO. 372-200 (REVISED 5-2000)

SAMPLE OF MEDICAID RESOLUTION INQUIRY

MEDICAID RESOLUTION INQUIRY

MAIL TO:
EDS PROVIDER SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: ☐ Medicare Override ☐Time Limit Override ☐Third Party Override

NOTE: PLEASE USE THIS FORM FOR **OVERRIDES AND INQUIRIES ONLY**.
CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED.
ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.

Provider Number: _____

Provider Name and Address: _____

_____

Patient's Name: _____Recipient ID: _____

Date of Service: From: / / to / /Claim Number: _____

Billed Amount: _____ Paid Amount: _____ RA Date: _____

Please Specify Reason for Inquiry Request:

Signature of Sender: Date: Phone #:

TO BE USED BY EDS ONLY

Remarks:

Revised 7/1/03

SAMPLE OF ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

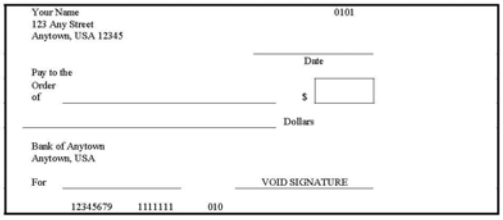
Attention: Medicaid Providers
Electronic Funds Transfer (EFT)
Authorization Agreement for Automatic Deposits
Request type (must be checked) ☐ Initial Request (Start) ☐ Change Request (Stop & Start) ☐ Cancel Request (Stop)

Electronic Data Systems offers Electronic Funds Transfer (EFT) as an alternative to paper check issuance. This service enables providers to have Medicaid payments deposited at a designated bank while continuing to receive Remittance and Status Reports (RA) at your mailing address of record. This process will guarantee payment in a timely manner and prevent your check from being lost through the mail.

To ensure timely and accurate enrollment in the EFT program, please fill out the form on this page, attach a voided check or a bank letter, and return it by mail or fax to:
EDS, 4905 Waters Edge, Raleigh, NC, 27606 OR 919-816-3186 ATTN – Finance
OR email to EFT@ncxix.hcg.eds.com

EDS will run a trial test between our bank and yours. This test will be done on the first checkwrite you are paid after we process this form. Initial requests normally take 2 checkwrites to finalize; changes require 1 additional checkwrite due to a cancellation period. Using EFT, your payments will go directly to your bank account. Your RA will continue to come through the mail. On the last page of your RA, in the top left corner, it will state "EFT number", rather than "Check number", when the process has begun. EFT Payments are usually effective one business day after each checkwrite date. Contact Provider Services at 1- 800-688-6696 with any questions regarding EFT.

Thank you for your cooperation in making this a smooth transition to EFT, and for helping us to make the Medicaid payment process more efficient for the Medicaid provider community.


Your Name
123 Any Street
Anytown, USA 12345

0101

Date

Pay to the Order of _____ $ ☐

_____ Dollars

Bank of Anytown
Anytown, USA

For _____ VOID SIGNATURE

12345679 1111111 010

PROVIDER NAME_____

DATE_____ BILLING PROVIDER NUMBER_____

TO STOP USING AN ACCOUNT - COMPLETE THIS SECTION

BANK NAME_____

BRANCH ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

BANK TRANSIT/ABA NO._____

ACCOUNT NO._____

CHECKING OR SAVINGS _____

TO START USING AN ACCOUNT - COMPLETE THIS SECTION

BANK NAME_____

BRANCH ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

BANK TRANSIT/ABA NO._____

ACCOUNT NO._____

CHECKING OR SAVINGS _____

Under penalties of perjury, we hereby certify the checking or savings account(s) indicated above is/are under our direct control and access. Therefore, we authorize Electronic Data Systems to initiate, change or cancel credit entries to those checking or savings account(s) and the bank name(s)as indicated above.

NAME: _____ _____
Printed Authorized Signature

Contact Name _____ Phone Number _____

⇦ **A VOIDED CHECK MUST BE ATTACHED FOR EACH BANK ACCOUNT IN ORDER FOR US TO PROCESS YOUR EFT. DO NOT SUBMIT DEPOSIT SLIPS. IF YOU DO NOT HAVE A CHECK, OBTAIN A LETTER FROM YOUR BANK VERIFYING ACCOUNT & ROUTING NUMBER.**

***EACH PROVIDER NUMBER REQUIRES A SEPARATE REQUEST**

Revised 2/2006